

COASTLINE IMAGING, INC.
2290 W. EAU GALLIE BLVD. SUITE 104 MELBOURNE, FL 32935
321-253-2700

PATIENTS NAME _____ DATE _____

SEX _____ DATE OF BIRTH _____ SSN _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE# _____ WORK# _____

E-MAIL ADDRESS _____

REFERRING DOCTOR _____ PHONE# _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATIONSHIP _____ PHONE# _____

ALTERNATE ADDRESS IF ONLY HERE PART OF THE YEAR:

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE# _____ DATES IN FLORIDA _____

*****IF PATIENT IS A MINOR OR STUDENT*****

PERSON RESPONSIBLE FOR CHARGES _____

RELATIONSHIP TO PT _____ SSN _____

ADDRESS (if different from pt's) _____

PHONE # _____ EMPLOYER _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____

POLICY HOLDER NAME _____ RELATION _____

SECONDARY INSURANCE NAME _____

ATTORNEY'S NAME _____ PHONE# _____

IS THIS RELATED TO AN INJURY FROM WORK ? ___ AUTO ACCIDENT? ___

DATE OF INJURY _____

****IF YOU HAVE FAILED TO INFORM US OF ANY INSURANCE PLANS THAT REQUIRE AUTHORIZATIONS FOR YOUR PROCEDURE YOU WILL BE RESPONSIBLE FOR THE BALANCE IF THAT INSURANCE IS FILED AND THEY HAVE DENIED THE CLAIM.****

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY MY BENEFITS DIRECTLY TO COASTLINE IMAGING, INC. I UNDERSTAND THAT I AM HELD FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY. I AGREE THE USE OF MY SIGNATURE FOR ALL MY INSURANCE CHECKS FOR PAYMENTS OF CLAIMS IF NECESSARY. I ALSO AUTHORIZE COASTLINE IMAGING, INC. TO RELEASE ANY PERTINENT INFORMATION THAT MAY BE NECESSARY TO AID MY INSURANCE COMPANY IN THE PAYMENT OF MY BENEFITS.

SIGNATURE _____

Patient / minor's parent or guardian



COASTLINE IMAGING, INC.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

| |
|----------------------------|
| NAME _____ |
| BIRTH DATE _____ SS# _____ |

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my healthcare information:

PATIENT:
X _____
Signature of Patient or Legal Representative Date Witness Signature

OFFICE USE ONLY

| | | | |
|-----------------------------------|-----------|-------|-------|
| <input type="checkbox"/> Accepted | _____ | _____ | _____ |
| <input type="checkbox"/> Denied | Signature | Title | Date |



COASTLINE IMAGING, INC.

RELEASE OF INFORMATION

IMPORTANT ***PLEASE READ***IMPORTANT

You are entitled to a COPY of your Medical Records, and of this Release of Information - release form. Copying of Medical Records is performed once per week.

Patient Name: _____ Acct. # _____

Birth Date: _____ Social Security #: _____ Phone: _____

I HEREBY REQUEST THE FOLLOWING INFORMATION:

Office Notes All Medical Records X-Rays Diagnostic Reports
 OP Reports Lab Results Billing Film Copies

THIS INFORMATION IS REQUESTED FROM: (Please fill in your Doctor's Name)

THIS INFORMATION WILL BE USED FOR: _____

PLEASE SEND TO:

Myself Attorney Treating Doctor State Disability Insurance Co.

NAME & ADDRESS: _____

THESE RECORDS CAN ALSO BE RELEASED TO: _____

By signing this form, I request and authorize release of the medical information noted above. This authorization is valid for one year unless otherwise noted. (_____)

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY:

Request completed by _____ Date _____

_____ Mailed _____ Faxed Picked up by: _____

(Please circle one: Patient Other)

MAIN OFFICE
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OPEI
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Sui
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